STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING _____ B. WING _____	03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILLION CONVALESCENT CENTER	1705 S MAIN ST CLINTON, IN47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure survey. Dates of survey: 3/1-4, 8/11 Facility number: 000052 Provider number: 155124 AIM number: 100290340 Survey team: Laura Brashear, RN, TC 3/1, 4, 8/11 Mary Weyls, RN Teresa Buske, RN Census bed type: SNF/NF: 100 Total: 100 Census payor type: Medicare: 9 Medicaid: 74 Other: 17 Total: 100	F0000	Submission of the plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of complaince	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 20 Supplemental: 1 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-11-11 Cathy Emswiller RN			

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F0224 SS=D	Based on interview and record review the facility failed to prevent misappropriation of resident property for 1 of 1 resident reviewed, identified with misappropriation of medication in a supplemental sample of 1, in that two staff nurses removed medication from the supply of the resident's medication for the staff persons own use. (Resident #16) (RN #3 and RN #4) Findings include: During interview of the Corporate RN, Administrator and DON (Director of Nursing) On 3/3/11 at 9:30 a.m., the Administrator indicated they were getting ready to send in a 5 day report on an incident to the ISDH (Indiana State	F0224	1. No residents were harmed.2. All residents residing within the facility are at risk. Medication was replaced at the facility's cost for resident #16. See #3 below for corrective action. The nurses involved were suspended immediately until the investigation was completed. Both were terminated on 3/4/11. The Attorney General was contacted and a report filed for misappropriation of property. Ombudsman notified, along with Adult Protective Services.3. The facility policy and procedures for abuse prohibition, resident abuse and resident to resident abuse were reviewed and no changes are indicated at this time (See attachment A). All staff were re-educatedon Abuse and "Drug Diversion". All Phenergan was locked and accounted for and continues to be counted every shift as a controlled substance. The DON or her designee will monitor to ensure shift-to=shift count is occurring daily on scheduled working days for 4 weeks, then weekly for 4 weeks then monthly for 3 months, then quarterly thereafter (See Attachment B).	03/28/2011

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	Department of Health). The DON indicated when she entered the facility on 3/28/11, at approximately 6:30 a.m., RN #14 indicated, QMA #15 had reported that the evening RN (RN #3) had entered the building at approximately 3 a.m., and had been in the medication cart on the north/west unit. The QMA had indicated when she ask him what he was doing, he told the QMA that he was getting some medication for his wife (RN #4) who was ill at home. RN #14 indicated she had called RN #3 and told him he needed to bring back the medication he took from the facility. RN #14 told the DON, RN #3 brought back two Immodium (anti-diarrheal) tablets and two Phenergan (anti-nausea)			

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	tablets. The DON indicated she called RN #3, and had him come in to the facility on 2/28/11. The DON indicated RN #3 indicated he was working on the evening shift on 2/27/11, and began feeling very sick. RN #3 indicated RN #4 gave him a syringe with phenergan, and he gave himself the injection. RN #3 then indicated his wife (RN #4) became ill in the early a.m., and that was the reason he re-entered the facility and took the medication. RN #3 indicated he took a vial of Phenergan, two Immodium tablets and two Phenergan tablets. RN #3 indicated he returned the tablets, but was unable to return the vial of phenergan due to having			

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	already administered the medication to his wife. The DON indicated the medication had been taken from Resident #16's medication supply. During review of the facility policy titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION", received on 3/1/11 at 2 p.m., from the Administrator, documentation indicated "Misappropriation of Resident Property-the deliberate misplacement, exploitation or the wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." On 3/4/11 at 3:00 p.m., the DON indicated the nurses were terminated on 3/4/11.			

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	3.1-28(a)			

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F0225 SS=D	Based on interview and record review the facility failed to ensure all alleged violations including misappropriation of resident's property were reported immediately to the Administrator for 1 of 1 residents reviewed in a supplemental sample of 1, in that staff persons took medication out of resident #16's medication supply and the Administrator was not made aware of the incident until entering the facility.(RN #3 and RN #4). Findings include: During interview of the Corporate RN, Administrator and DON (Director of Nursing) On 3/3/11 at 9:30 a.m., the Administrator indicated they were getting ready to send in a	F0225	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed.2. All residents residing within the facility are at risk Medication was replaced at the facility's cost for resident #16. See #3 below for corrective action. The nurses involved were suspended immediately until the investigation was completed. Both were terminated on 3/4/11. The Attorney General was contacted and a report filed for misappropriation of property. Ombudsman notified, along with Adult Protective Services.3. The facility policy and procedures for abuse prohibition, resident abuse, and resident to resident abuse were reviewed and no changes are indicated at this time (See Attachment C). Staff were re-educated on Abuse, in particular ensuring all potential violations are reported immediately to the facility administrator. The DON will question 5 random licensed staff regarding abuse at the following intervals: 5 per week for four weeks, then 5 per month for three months, then 5 per quarter (See Attachment D). The Administrator or her designee will do same but with 5 non-licensed employees (See Attachment E) at the same intervals to ensure vilations are being reported immediately.4. The findings of	03/28/2011

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	5 day report on an incident to the ISDH (Indiana State Department of Health). The DON indicated when she entered the facility on 2/28/11, at approximately 6:30 a.m., RN #14 indicated, QMA #15 had reported that the evening RN (RN #3) had entered the building at approximately 3 a.m., and had been in the medication cart on the north/west unit. The QMA had indicated when she ask him what he was doing, he told the QMA that he was getting some medication for his wife (RN #4) who was ill at home. RN #14 indicated she had called RN #3 and told him he needed to bring back the medication he took from the facility. RN #14 told the DON, RN #3 brought back two Immodium		these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective actions will be completed on or before 3/28/11.	

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	(anti-diarrhea) tablets and two Phenergan (anti-nausea) tablets. The DON indicated the medication had been taken from Resident #16's medication supply. The DON indicated she and the Administrator had not been notified of the incident until they entered the building on 2/28/11 at 6:30 a.m. During review of the facility policy titled "Reporting Unusual Occurrences to the State", on 3/1/11 at 2 p.m., provided by the Administrator, the policy indicated the Administrator would be notified immediately of an alleged violation involving misappropriation of resident			

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	property. On 3/4/11 at 3:00 p.m., the DON indicated the nurses had been terminated on 3/4/11. 3.1-28(c)			

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F0226 SS=D	Based on interview and record review the facility failed to implement policies concerning misappropriation of resident property as well as reporting timely, for 1 of 1 resident in a supplemental sample of 1, in that staff took medication from resident #16's medication supply and the Administrator was not immediately notified when medication was taken from resident #16's medication supply. (Resident #16) (RN #3 and RN #4) Findings include: During interview of the DON on 3/2/11 at 9:30 a.m., the DON indicated when she entered the facility on 2/28/11, at approximately 6:30 a.m., RN #14 indicated, QMA #15 had reported that the evening RN	F0226	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed.2. All residents residing within the facility are at risk. Medication was replaced at the facility's cost for resident #16. See #3 below for corrective action. The nurses involved were suspended immediately until the investigation was completed. Both were terminated on 3/4/11. The Attorney General was contacted and a report filed for misappropriation of property. Ombudsman notified, along with Adult Protective Services.3. The facility policy and procedures for abuse prohibition, resident abuse and resident to resident abuse were reviewed and no changes are indicated at this time (See Attachment A). Staff were re-educated on Abuse, in particular ensuring all potential violations are reported immediately to the facility Administrator. The DON will question 5 random licensed staff regarding abuse at the following intervals: 5 per week for four weeks, then 5 per month for three months, then 5 per quarter (See Attachment C). The Administrator or her designee will do same but with 5 non-licensed employees (See Attachment C) at the same intervals to ensure violations are being reported immediately.4. The findings of	03/28/2011

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	(RN #3) had entered the building at approximately 3 a.m., and had been in the medication cart on the north/west unit. The QMA had indicated when she ask him what he was doing, he told the QMA that he was getting some medication for his wife (RN #4) who was ill at home. RN #14 indicated she had called RN #3 and told him he needed to bring back the medication he took from the facility. RN #14 told the DON, RN #3 brought back two Immodium (anti-diarrhea) tablets and two Phenergan (anti-nausea) tablets. The DON indicated the medication had been taken from Resident #16's medication supply.		these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective actions will be completed on or before 3/28/11	

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	The DON indicated she and the Administrator had not been notified of the incident until they entered the building on 2/28/11 at 6:30 a.m. During review of the facility policy titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION", received on 3/1/11 at 2 p.m., from the Administrator, documentation indicated "Misappropriation of Resident Property-the deliberate misplacement, exploitation or the wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." During review of the facility policy titled "Reporting Unusual Occurrences to the State", on 3/1/11 at 2 p.m.,			

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	provided by the Administrator, the policy indicated the Administrator would be notified immediately of an alleged violation involving misappropriation of resident property. On 3/4/11 at 3:00 p.m. the DON indicated the nurses were terminated on 3/4/11. 3.1-28(a)			

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F0323 SS=D	Based on observation, interview, and record review, the facility failed to ensure safety for 3 of 3 residents observed transferred with mechanical lifts in a sample of 20 in that manufacturer's guidelines were not followed. [Residents #101, #7, 61] Findings include: 1. On 3/1/11 at 11:40 a.m., with LPN #11, Resident #101 was identified as utilized a mechanical lift for transfers. On 3/8/11 at 11:00 a.m., CNAs #12 and #13 were observed to transfer Resident #101 from the bed to wheelchair with the Invacare Reliant 450 mechanical lift. The Resident was observed positioned on the lift sling in bed. The CNAs	F0323	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.The facility feels it has met this requirement through the following corrective measures:1. Resident # 101,#7, and #61 suffered no actual harm.2. Residents who require the use of a mechanical lift have the potential to be affected.3. The policy and procedure for mechanical lift use (See Attachment D) and the lift manufacturer's instructions were reviewed. The policy requires no changes at this time. Licensed and non-licensed nursing staff were re-educated regarding both(See Attachment E) The Director of Nursing or designee will complete competency check offs for Mechanical Lift three times daily on scheduled work days for 2 weeks, then daily on scheduled work days for two weeks, then weekly for four weeks, then monthly for two months, then quarterly (See Attachment F).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 3/28/11.	03/28/2011

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	were observed to attach the sling to the lift. The fabric was observed to be torn on two of four corners of the sling that attach to the lift. The CNAs indicated they had not noticed the torn fabric. CNA #12 exited the room to obtain another sling. The second sling was observed to have a worn, frayed loop [hook]. CNA #12 indicated she had not noticed that, and exited the room to obtain another sling. On 3/8/11 at 11:15 a.m., CNAs #12 and #13 indicated both ends of the building had received two new lift pads. After positioning Resident #101 on the third lift pad, the sling was attached to the lift. With the base of the lift under the bed in closed position, the			

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	rear casters were locked. The resident was raised several inches above the surface of the mattress. The lift was pulled away from the bed, and with the resident perpendicular to the mast and in the elevated position transferred to the wheelchair. The base of the lift was opened around the wheelchair the rear castors locked. The resident was turned toward the mast and lowered into the wheelchair. Resident #101's clinical record was reviewed on 3/1/11 at 2:45 p.m. The Minimum Data Set [MDS] assessment, completed on 12/7/10, coded the resident as required total assistance of two for transfers, non-ambulatory. A physician's order [no date] was noted of hoyer transfer with assistance			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of two on the most recent monthly recapitulation [March, 2011.]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING _____ B. WING _____	03/08/2011

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VERMILLION CONVALESCENT CENTER	1705 S MAIN ST CLINTON, IN47842

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F0323 SS=D	2. On 3/3/11 at 11:10 a.m., CNAs #8 and #9 were observed to transfer Resident #7 from the bed to the wheelchair utilizing the Invacare Reliant 450 hoyer mechanical lift. The resident was observed to be lifted off the surface of the bed six inches and remained at the same height when transferred to the wheelchair. The resident did not face the operator. CNA #9 was observed to tip the locked wheelchair backwards and grab the sling to pull towards the back of the seat. The resident was then lowered into the wheelchair. Review of the clinical record of Resident #7 on 3/2/11 at 11:30 a.m. indicated the most recent Minimum Data Set (MDS) was completed 1/9/11. The assessment identified the	F0323	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.The facility feels it has met this requirement through the following corrective measures:1. Resident # 101,#7, and #61 suffered no actual harm.2. Residents who require the use of a mechanical lift have the potential to be affected.3. The policy and procedure for mechanical lift use (See Attachment D) and the lift manufacturer's instructions were reviewed. The policy requires no changes at this time. Licensed and non-licensed nursing staff were re-educated regarding both(See Attachment E) The Director of Nursing or designee will complete competency check offs for Mechanical Lift three times daily on scheduled work days for 2 weeks, then daily on scheduled work days for two weeks, then weekly for four weeks, then monthly for two months, then quarterly (See Attachment F).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 3/28/11.	03/28/2011

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	resident required total dependence for transfers. An physician's order was noted dated 1/20/11 of resident to be hoyer lift only due to resident's non-compliance.			

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F0323 SS=D	3. On 3/8/11 at 9:50 a.m., CNA #'s 1 and 2 transferred Resident #61 from a geri-chair to bed utilizing a "Invacare Reliant 450." Prior to lifting the resident from the geri-chair, CNA #1 locked the wheels on the mechanical lift. Manufacturer's directions, provided by the DON on 3/8/11 at 12:30 p.m., included, but was not limited to: "...When using an adjustable base lift, the legs MUST BE in the maximum OPENED/LOCKED position BEFORE lifting the patient. ...WARNING Invacare does NOT recommend locking of the rear casters of the patient lift when lifting an individual. Doing so could cause the lift to tip and endanger the patient and attendants. Invacare DOES recommend that the rear	F0323	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.The facility feels it has met this requirement through the following corrective measures:1. Resident # 101,#7, and #61 suffered no actual harm.2. Residents who require the use of a mechanical lift have the potential to be affected.3. The policy and procedure for mechanical lift use (See Attachment D) and the lift manufacturer's instructions were reviewed. The policy requires no changes at this time. Licensed and non-licensed nursing staff were re-educated regarding both(See Attachment E) The Director of Nursing or designee will complete competency check offs for Mechanical Lift three times daily on scheduled work days for 2 weeks, then daily on scheduled work days for two weeks, then weekly for four weeks, then monthly for two months, then quarterly (See Attachment F).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 3/28/11.	03/28/2011

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	casters be left unlocked during lifting procedures to allow the patient lift to stabilize itself when the patient is initially lifting from a chair, bed or any stationary object. ... When moving the patient lift away from the bed, turn patient /so that he/she faces attendant operating the patient lift. Turn crank handle counterclockwise (manual) or open control valve (hydraulic) lowering patient so that his feet rest on or over the base of the lift, straddling the mast. Close control valve. NOTE: The lower center of gravity provides stability making the patient feel more secure and the lift easier to pull or push. NOTE: DO NOT use the rear locking casters when patient is in the lift."			

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	The DON was interviewed on 3/8/11 at 4:00 p.m. The DON indicated it was the facility policy not to utilize lift pads when worn, frayed, or torn. 3.1-45(a)(2)			

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F0371 SS=E	Based on observation, record review and interview the facility failed to ensure ice was served under sanitary condition for 1 of 3 ice machine in that one ice machine was observed to have a black/brown substance on the inside top of the machine. This affected the 49 residents on the northside of the building. Findings include: During General Observation tour on 3/8/11 with the Maintenance Supervisor and Housekeeping Supervisor, which started at 1:30 p.m., the ice machine on the north unit was noted with a black/brown substance on the edge of the plastic insert at the top of the inside of the ice machine.	F0371	1. No residents were affected.2. All residents have the potential to be affected. The top of the ice machine was immediately cleaned. 3. The facility presented an in-service on cleaning stainless steel and sanitation terminology. (See attached Policy #G, and inservice sign-in sheets(Attachment H). A revised cleaning schedule was posted and is being monitored by the dietary manager 5 times weekly for two weeks, then weekly times 2 weeks, then monthly as part of the facility's on going Quality Assurance Program (See Attachment I).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly.5. The above corrective actions will be completed on or before 3/28/11.	03/28/2011

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	During interview of the Maintenance Supervisor on 3/8/11 at 2 p.m., the supervisor indicated the maintenance department was responsible for cleaning and sanitizing the ice machine. During interview of the Maintenance Supervisor on 3/8/11 at 2:30 p.m., the supervisor indicated the last time north ice machine had been cleaned was on 1/12/11. 3.1-21(i)(3)			

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F0494 SS=D	Based on record review and interview the facility failed to ensure all individuals working in the facility as a nurse aide for more than 4 months on a full-time basis had completed a training and competency evaluation program and/or deemed competent for 2 of 45 CNAs employed by the facility in that CNAs #5 and #6 were working in the facility as nurse aides for more than 4 months and did not have a current Indiana CNA registry certification. Findings include: 1. Review of the personnel file of CNA # 5 on 3/8/11 at	F0494	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed. Staff member #5's employment was terminated. Staff member #6 resigned her positon.2. All residents have the potential to be affected. A thorough review of all employee files was conducted to ensure appropriate certification or licensure has been retained at the facility and that all employees hold said credentialing within 120 days of employment.3. Human Relations staff and the Director of Nursing were be re-educated on hiring requirements (See Attachment J). The Administrator or her designee will audit all prospective employees' information provided prior to hiring to ensure criteria are met(See Attachment K).4. The results of these audits will be reviewed during the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly.5. The above corrective actions will be completed on or before March 28, 2011.	03/28/2011

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	4 p.m. indicated the CNA had been hired as a nurse aide on 7/21/10. The personnel file contained information that the CNA had completed the nurse aide training competency evaluation program in Illinois on 9/21/2001. A current Indiana CNA registry certification was lacking. Interview of the Administrator on 3/8/11 at 4:40 p.m. indicated CNA #5 had been employed as a nurse aide for more than 4 months and that she did not have a current Indiana CNA registry certification.			

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	2. Review of the personnel file of CNA #6 on 3/8/11 at 4 p.m. indicated the CNA had been hired as a nurse aide on 5/12/10. The personnel file contained information that the CNA was enrolled in a college nursing program. A current Indiana CNA registry certification was lacking. Interview of the Administrator on 3/8/11 at 4:40 p.m. indicated CNA #6 had been employed as a nurse aide for more than 4 months and that she had completed fundamentals of nursing in her nursing program. The Administrator indicated that she did not			

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	have a current Indiana CNA registry certification. The Administrator indicated it was the facility's policy to that staff working as a nurse aide would have Indiana CNA registry certification within the 120 days from date of hire. 3.1-14(b)(2)(A) 3.1-14(b)(2)(B)			

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F0516 SS=E	Based on observation, record review and interview the facility failed to safeguard 12 of 12 plastic totes containing discharged medical records from unauthorized use in that clinical records were stored in a storage shed, which the maintenance person had keys to. Findings include: During General Observation tour on 3/8/11, with the Maintenance Supervisor, which began at 1:30 p.m., the supervisor used a key on his key ring to open a storage shed. Twelve large plastic totes were observed. The Supervisor indicated the totes contained discharged residents' medical records.	F0516	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed.2. All residents have the potential to be affected.3. Medical records personnel and Maintenance Supervisor were re-educated on the policy regarding safeguarding of clinical records (See Attachment L). The administrator or her designee will monitor clinical records storage three times weekly for four weeks, then weekly for four weeks, then monthly for three months, then quarterly (See Attachment M).4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting.5. The above corrective measures will be completed on or before 3/28/11.	03/28/2011

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	During interview of the Administrator on 3/8/11 at 2:25 p.m., the Administrator indicated the Maintenance Supervisor was not a licensed person authorized to have access to the records and should not have access to medical records. During review of a facility policy titled "MEDICAL RECORDS POLICY", on 3/8/11 at 2:25 p.m., the policy indicated "Clinical records will be safeguarded against loss, destruction and unauthorized use by storing in file cabinets in a locked area." 3.1-50(d)			